STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

September 5, 2018

Andrew Agwunobi, Administrator
John Dempsey Hospital
263 Farmington Avenue
Farmington, CT 06032

Dear Mr. Agwunobi:

Unannounced visits were made to John Dempsey Hospital on May 29, June 4 and July 12, 2018 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for October 2, 2018 at 10:00AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to retain legal representation, your attorney may accompany you to this meeting. Please be prepared to discuss those violations Identified with an asterisk.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by September 19, 2018 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.
4. Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

We do not anticipate making any practitioner referrals at this time.

Should you have any questions, please do not hesitate to contact this office at (860) 509-7400.

FACILITY: John Dempsey Hospital

DATES OF VISIT: May 29, June 4 and July 12, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Respectfully,

SNN

Susan Newton, RN, BS
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SHN:mb

Complaint #23456

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(B) and/or (d) Medical Records (3).

1. Based on medical record reviews and interviews for 2 (P#1 and P#2) of 4 patients with a change in condition, the hospital failed to ensure that a practitioner's patient assessment was documented and/or that documentation was timed accordingly. The findings include:
   a. Patient #1 was admitted to the hospital on 1/10/18 with diagnoses that included congestive heart failure (CHF), hypertension (HTN), chronic obstructive pulmonary disease (COPD) and coronary artery disease (CAD). P#1's cardiac status was monitored via a telemetry monitor.
   A cardiology progress note by Medical Doctor (MD) #1 dated 1/14/18 at an unidentified time indicated P#1's breathing had improved, had a regular cardiac rhythm and no further complaints were offered. The plan of care indicated P#1 would continue on a Lasix (diuretic) drip and his/her fluid and electrolytes would be monitored.
   On 1/14/18 at 9:30 AM MD #1 ordered for P#1 to receive Metoprolol 5 milligrams (mg.) intravenous one time and Heparin 25000 units in 500 milliliters (ml) of 0.45% normal saline intravenous drip. Review of the medical record failed to identify that an assessment had been documented by MD#1 prior to initiation of the treatment with Metoprolol and Heparin for atrial fibrillation (a-fib).
   A physician progress note by MD#2 dated 1/14/18 at 4:00 PM indicated MD#2 had been informed that P#1's telemetry monitor had been switched with another patient who was experiencing (a-fib) with rapid ventricular response (RVR). The note indicated before the error was identified, P#1 received a rate control agent and a heparin drip without bolus for two hours (in error). MD#2 indicated in the progress note the incident and subsequent treatment caused P#1 no ill effects.
   During an interview with MD#1 on 5/31/18 at 8:00 AM, MD#1 indicated his initial assessment was not timed however had occurred prior to P#1 exhibiting atrial fibrillation on the monitor. MD#1 indicated when notified that P#1 was experiencing atrial fibrillation he/she did assess P#1 for symptoms of a-fib, however did not document the assessment in P#1's medical record.
   b. Patient #2 was admitted to the hospital on 1/12/18 with diagnoses that included acute decompensated congestive heart failure (CHF) and persistent atrial fibrillation with rapid ventricular response. P#2's cardiac status was monitored via a telemetry monitor. Although P#2 was experiencing a-fib, P#2's monitor did not reflect that the patient was experiencing a-fib because P#1 and P#2's monitors had been switched in error.
   An assessment of P#2 completed by MD#1 dated 1/14/18 lacked documentation of the time the assessment was completed. A subsequent assessment documented by MD#2 was dated 1/14/18 at 11:00 AM.
   P#2 did not experience any ill effects due to the delay in receiving treatment for his/her a-fib.
   Medical Staff bylaws indicated each member of the medical staff would provide patients with continuous high quality care meeting the professional standards of the medical staff of

the hospital. In addition the medical staff rules and regulations indicated all written entries in the medical record should include the date and time of the note.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing service (1).

2. Based on review of hospital documentation and interviews for patients on cardiac telemetry monitoring the hospital failed to ensure monitoring documentation was recorded according to hospital practice. The findings include:
   a. During a review of hospital investigative documentation it was identified on 1/14/18 that a print out of telemetry monitoring strips was not completed at 7:00 AM due to the unavailability of telemetry strip paper.
   During an interview with Technician #1 on 5/31/18 at 10:20 AM he/she indicated that at the start of the shift on 1/13/18 at 1:00 PM telemetry strip paper was not available therefore Technician #1 printed the strips for all patients on telemetry on alternate paper.
   During an interview with Technician #2 on 5/31/18 at 11:00 AM he/she indicated that at the start of the shift on 1/14/18 at 7:00 AM telemetry strip paper was not available. He/she did not know how to obtain additional paper therefore he/she did not print out telemetry strips for all patients on telemetry monitoring.
   A hospital procedure for CMU (Cardiac Monitoring Unit) printing of telemetry strips indicated telemetry rhythm strips should be printed for all patients on telemetry at shift start and the strip should be measured and analyzed.
   Subsequent to 1/14/18 all staff of the CMU was educated on how to obtain telemetry paper when stock is not available.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (i) General (6).

3. *Based on medical record review and interviews for 2 (Patients#1 and 2) of 12 patients reviewed for cardiac monitoring via telemetry monitoring devices, the hospital failed to ensure that staff followed the hospital procedure for wireless telemetry device application and monitoring resulting in Patient #1 receiving treatment for Patient #2's cardiac arrhythmia (atrial fibrillation). The findings include:
   Patient #1 was admitted to the hospital on 1/10/18 directly from the cardiology clinic for decompensated heart failure. Patient #1's history included congestive heart failure, hypertension, chronic obstructive pulmonary disease and coronary artery disease. Patient #1 was admitted to Room 208 of the Intermediate Unit (IU). A cardiology progress note by Medical Doctor (MD) #1 dated 1/14/18, at an unidentified time, indicated Patient #1's breathing had improved, had a regular cardiac rhythm and no further complaints were offered. The plan of care indicated Patient #1 would continue on a Lasix (diuretic) drip and his/her fluid and electrolytes would be monitored.
   Patient #2 was admitted to the hospital on 1/12/18 after elective right and left cardiac

catheterization for rate control. Patient #2's history included decompensated congestive heart failure and persistent atrial fibrillation (a-fib) with rapid ventricular response. Patient #2 was admitted to Room 215 of the intermediate unit.

a. On 1/14/18 at 4:00 AM Registered Nurse (RN) #1 requested a telebox (portable telemetry monitoring device) for Patient #1 from the Cardiac Monitoring Unit (CMU) via phone. RN#1 was instructed by Technician #1 that a telebox was not available from the cardiac monitoring unit at that time and to obtain one from the intermediate unit as is usual procedure. RN #1 obtained telebox #13 and placed it on Patient #1. Review of the hospital's post incident analysis identified that following placement, RN#1 and Technician #1 failed to verify telebox #13's application (placement on the patient) and failed to obtain a patient rhythm, as is usual procedure.
The hospital process for telebox assignment included in part, assignment is based on the patient's room number.
Interview with RN#1 on 5/31/18 at 9:15 AM identified that on 1/14/18 at 4:00 AM he requested a telebox from the cardiac monitoring unit via phone and was instructed by Technician #1 that a telebox was not available and to obtain one from the intermediate unit as was usual procedure. RN#1 indicated after obtaining telebox #13 he put it on Patient #1 and notified Technician #1 that Patient #1 was on telebox #13. RN #1 identified that he did verify the rhythm on Patient #1's telebox and it indicated normal sinus rhythm.

b. At 5:51 AM RN#1 went to the cardiac monitoring unit, signed out, and removed telebox #15. RN#1 told Technician #1 that he was taking telebox #15 for room 215 (Patient #2). Review of the hospital's post incident analysis identified that following placement, RN#1 and Technician #1 failed to verify telebox #15's application (placement on the patient) and failed to obtain a patient rhythm, as is usual procedure.
Hospital process for obtaining a telebox was to call (not go to) the cardiac monitoring unit and request a box. Then transport staff would bring the telebox and appropriate paperwork to the intermediate unit for patient use.
At 5:52 AM, according to the Connexall system (the hospital's cardiac monitoring system), Patient#1 was switched from telebox #13 to telebox #15.
Interviews with RN #1 and Technician #1 failed to identify how Patient #1's telebox was switched from telebox #13 to telebox #15.
At 5:53 AM Technician #1 identified Patient #2's bedside monitor indicated "check leads". Technician #1 attempted to contact RN#1 to verify the telebox and bedside monitor readings however RN#1 was not signed into the Voalte system (staff communication system) and could not be reached via this communication system. At that time, Technician #1 failed to communicate with RN#1 in another manner and/or failed to contact another nurse regarding Patient #2's status. It was later identified that RN #1 was not signed into the staff communication system from 3:00 AM to 8:00 AM and should have been, as was the hospital process.
Interview with RN#1 on 5/31/18 at 9:15 AM identified that on 1/14/18 he went to the cardiac monitoring unit, signed out, and removed telebox #15. RN#1 told Technician #1 he/she was taking telebox #15 for room 215 (Patient #2). RN#1 then proceeded to Patient

#2's room, applied telebox #15 and checked the rhythm, which showed normal a-fib. RN#1 indicated that he believed that the telebox switch occurred at 5:50 AM when Technician #1 had changed P#1 from telebox #13 to telebox #15.
Interview with Technician #1 on 5/31/18 at 10:20 AM identified that on 1/14/18 at approximately 5:00 AM a staff member hurriedly came into the cardiac monitoring unit, took telebox #15, indicated several times that he was taking the telebox for room 215 (Patient #2), and then ran out of the room. Technician #1 indicated the staff member did not identify who he was, but another technician in the room (Technician #3) identified him as RN#1. According to the Voalte system (staff communication system) the nurse assigned to room 215 was not RN#1. Technician #1 indicated that after RN#1 left the room, Technician #1 and Technician #3 together assigned telebox #15 to room 215 (Patient #2). Technician #1 indicated that normal procedure was that when a telebox is removed from the cardiac monitoring unit, a form attached to the telebox is completed with the patient name, room number, date and time and placed in the slot where the specific telebox is stored. Once the telebox is connected to the patient the nurse calls or sends a message to the cardiac monitoring unit verifying that the patient is connected. However in this situation RN#1 did not complete the form and the cardiac monitoring unit did not receive a confirmation message from RN#1. Technician #1 was able to see on the monitoring system that room 215 (Patient #2) had been removed from the bedside monitor. Therefore Technician #1 and Technician #3 connected room 215 (Patient #2) to telebox #15, which completed an 11 step process to register the telebox to that particular patient. Technician #1 indicated that shortly after connecting Patient #2 to telebox #15, room #208 (Patient #1's) telebox was registering a heart rate in the 150's. Technician #1 messaged the nurse assigned to room #208 (Patient #1) via the Voalte system (staff communication system) but did not receive a response back. Technician #1 then reported off to Technician #2 between 7:00 AM and 7:30 PM.

c. At 7:30 AM Technician #1 reported off to Technician #2. Technician #2 noticed telebox #15 (assigned to Patient #2) was alarming high heart rate (203) and was unable to reach RN#1 so she called the intermediate unit and reported the high heart rate. Technician #2 was unable to identify who she reported the high heart rate to.
At 8:00 AM Technician #2 notified RN#1, via the Volte system (staff communication system), that telebox #15 continued to sustain a heart rate of 180's-190's. RN#1 responded and indicated he would evaluate the high heart rate.
At 8:26 AM Technician #2 notified RN#1 that telebox #15 continued to indicate a high heart rate. RN#1 responded via the Voalte system "OK".
At 8:38 AM Technician #2 notified RN#1 that Patient #2 had been on the bedside monitor and was now "off monitor". At 8:39 AM RN#1 indicated Patient #2 was in the bathroom. Technician #2 notified RN#1 that if RN#1 wanted Patient #2 on a telebox, telebox #15 should be located in Patient #2's room (room 215).
At 8:44 AM the Connexall log identified that Patient #2 was placed on telebox #13. According to the Voalte (communication) system log, Technician #2 notified RN#1: "Patient #1 (room 208) is on tele box #15 and Patient #2 (room 215) is on telebox #13". There was no response from RN #1.

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At 9:21 AM MD#1 was notified that telebox #15 indicated Patient #1 was exhibiting atrial fibrillation. MD#1 verified the a-fib on the monitor and instructed RN#1 to obtain an Electrocardiogram (EKG). The EKG showed normal sinus rhythm (NSR). MD#1 consulted with MD#2.

At 9:30 AM MD#1 ordered Patient #1 to receive Metoprolol 5 milligrams (mg.) intravenous one time. Interview with RN #1 on 5/31/18 at 9:15 AM identified that at that time, he had to take another patient for an immediate CT-scan and asks RN#2 to cover his patients. RN#2 noted the order for Metoprolol and messaged RN#1 to verify that it had not yet been given. RN#1 verified the Metoprolol had not been given and RN#2 administers the Metoprolol 5 mg. IV at 10:19 AM.

At 10:43 AM MD#1 ordered Patient #1 to receive Heparin 25000 units in 500 milliliters (ml) of 0.45% normal saline intravenous (IV) drip. Between 10:43 AM and 1:16 PM, 2 EKS's were obtained, an additional IV access was obtained as well as ordered laboratory bloodwork according to protocol, followed by initiating the Heparin drip which was started at 1:16 PM.

At approximately 2:00 PM RN#1 went to the cardiac monitoring unit to verify Patient #1 and Patient #2's monitor rhythms. At that time, it was identified that Patient #1 and Patient #2's telebox's were on the wrong corresponding patients. Therefore Patient #2 was experiencing a-fib, not Patient #1. MD#1 was notified and Patient #1's Heparin drip was immediately stopped.

A physician progress note by MD#2 dated 1/14/18 at 4:00 PM indicated MD#2 had been informed that Patient #1's telemetry monitor had been switched with another patient and that the other patient was experiencing a-fib with rapid ventricular response, not Patient #1. The note indicated before the error was identified, Patient #1 received a rate control agent and heparin drip without bolus for two hours. MD#2 indicated in the progress note the incident and subsequent treatment did not cause Patient #1 any ill effects.

Interview with Technician #2 on 5/31/18 at 11:00 AM identified that communication between Technician #2 and RN#1 occurred at several points in the morning on 1/14/18. Communication included verifying the elevated heart rate of Patient #1 and/or Patient #2's telebox's and the patients being on or off bedside monitor. Technician #2 identified that RN#1 would respond to the messages, however there were several times when Technician #2 and RN#1 differed on what they were seeing on the monitors. Example: Technician #2 would identify that the patient was off monitor and RN#1 would indicate he thought the patient was on the telebox.

Interview with MD#1 on 5/31/18 at 8:00 AM MD#1 indicated he/she was notified by RN#1 that Patient #1's telebox was showing a-fib. MD#1 then verified Patient #1's rhythm on the monitor in the charting room as a-fib (room 208). MD #1 indicated he/she then ordered an EKG and went to examine Patient #1. Upon exam and questioning, Patient #1 exhibited no signs or symptoms of a-fib. A review of the EKG showed Patient #1 was in normal sinus rhythm. MD#1 indicated it is not uncommon for a patient to go in and out of a-fib, therefore explaining why the EKG showed a normal sinus rhythm. MD#1 consulted with MD#2, and P#1 was diagnosed with new onset a-fib for which heparin was indicated. MD#1 indicated

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that at approximately 2:00 PM, he/she was notified that Patient #1 and Patient #2's telebox's were on the wrong corresponding patients and the heparin drip had been turned off.
Interview with MD#2 on 5/31/18 at 8:00 AM identified that he/she had been consulted by MD#1 and the course of treatment provided to Patient #1 based on his/her a diagnoses of atrial fibrillation was appropriate. MD#2 indicated there were no complications or ill effects to Patient #1 as a result of receiving Metoprolol and Heparin. In addition, Patient #2 did not experience any ill effects due to the delay in receiving treatment for his/her a-fib.
According to the Instructions for application and use of the wireless telemetry monitoring device: 1) call the cardiac monitoring unit with the patients name, bed number, and request a telebox; 2) when transport arrives with the telebox collect the telebox and complete the form and confirm the patient identification; 3) Disconnect the bedside monitor wires and connect to the telebox; 4) Voalte message with patients name, bed number and request for transmission confirmation; 5) wait for confirmation from the cardiac monitoring unit.
Interviews and a review of events with Compliance Officers #1 and #2 on 6/4/18 identified that the hospital implemented the following interventions after the incident occurred: 1) reeducation on nursing communication systems (Voalte), telebox verification and the implementation of a telebox tracking log; 2) implementation of an escalation (notification) process for cardiac monitoring staff when telemetry alarms are sustained, including the addition of rhythm log and communication log; 3) reeducation on monitoring of supplies in the cardiac monitoring unit and how to acquire additional supplies; 4) monitoring and audits of compliance as scheduled.
On 6/27/18 at approximately 3:00 PM P#16 (room 226) was switched from bedside wired monitor to a telebox to ambulate with Physical Therapy and Nursing. Upon return of P#16 to room 226 Nursing called the central monitoring unit (CMU) to tell them to place room 226 back on hardwire monitor. CMU immediately called indicating room 225 had been placed on telebox not room 226. Error was corrected within 3-5 minutes and no ill outcome to either patient.
The patients in room 225 and 226 continued to be monitored by either hardwired bedside monitor or telebox during this time.
During an interview with Senior Nursing Director on 7/12/18 at 10:15 AM he/she indicated telebox's have been removed from the Intermediate Unit (IU) and all patients will be monitored when ambulating via the cube of the hardwired bedside monitor and with an escort of a registered nurse. Senior Nursing Director indicated in September 2018 it is planned that the IU will begin using a program in which the switch over from BSM to portable will be done automatically and will not require manual entry of patient information therfore eliminating possible entry of incorrect information.

Barnett, Marylin

From: Abromaitis,Debra <abromaitis@uchc.edu>
To: Barnett, Marylin
Sent: Wednesday, September 05, 2018 10:00 AM
Subject: Read: John Dempsey Hospital Office Conference violation letter-CT#23456

Your message

To:
Subject: John Dempsey Hospital Office Conference violation letter-CT#23456
Sent: Wednesday, September 5, 2018 9:59:50 AM (UTC-05:00) Eastern Time (US & Canada)

was read on Wednesday, September 5, 2018 9:59:48 AM (UTC-05:00) Eastern Time (US & Canada).

Approved 9/10/18 SHN

Violation	Discussion of Issues	Measures to Prevent Reoccurrence/Date Corrective Action Effected/Responsible party
The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(B) and/or (d) Medical Records (3).	1. Based on medical record reviews and interviews for 2 (P#1 and P#2) of 4 patients with a change in condition, the hospital failed to ensure that a practitioner's patient assessment was documented and/or that documentation was timed accordingly. The findings include: a. Patient #1 was admitted to the hospital on 1/10/18 with diagnoses that included congestive heart failure (CHF), hypertension (HTN), chronic obstructive pulmonary disease (COPD) and coronary artery disease (CAD). P#1's cardiac status was monitored via a telemetry monitor. A cardiology progress note by Medical Doctor (MD) #1 dated 1/14/18 at an unidentified time indicated P#1's breathing had improved, had a regular cardiac rhythm and no further complaints were offered. The plan of care indicated P#1 would continue on a Lasix (diuretic) drip and his/her fluid and electrolytes would be monitored. On 1/14/18 at 9:30 AM MD #1 ordered for P#1 to receive Metoprolol 5 milligrams (mg.) intravenous one time and Heparin 25000 units in 500 milliliters (ml) of 0.45% normal saline intravenous drip. Review of the medical record failed to identify that an assessment had been documented by MD#1 prior to initiation of the treatment with Metoprolol and Heparin for atrial fibrillation (a-fib). A physician progress note by MD#2 dated 1/14/18 at 4:00 PM indicated MD#2 had been informed that P#1's telemetry monitor had been switched with another patient who was experiencing (a-fib) with rapid ventricular response (RVR). The note indicated before the error was identified, P#1 received a rate control agent and a heparin drip without bolus for two hours (in error). MD#2 indicated in the progress note the incident and subsequent treatment caused P#1 no ill effects. During an interview with MD#1 on 5/31/18 at 8:00 AM, MD#1 indicated his initial assessment was not timed however had occurred prior to P#1 exhibiting atrial fibrillation on the monitor. MD#1 indicated when notified that P#1 was experiencing atrial fibrillation he/she did assess P#1 for symptoms of a-fib, however	1a & b. **Action:** • Implementation of EPIC HealthONE electronic health record on 4/28/2018 eliminates manual entry of dating and timing for progress notes. • Educate practitioners to document the time they actually saw the patient, when there's a change in condition, and when there's a significant time interval between evaluation and documentation. • Educate the practitioners that they are responsible for the timely document in the medical record of any meaningful change in a patient's condition or therapeutic plan, including any respective assessment. **Compliance Monitor:** Audit 10 charts per month of documentation of significant changes in condition in patients within the Intermediate Care Unit for a minimum of three months. Will continue observations until 10 consecutive observations with 100% compliance rate is achieved. The need for additional monitoring will be re-evaluated at that time. **Responsible Person:** Medical Director of Cardiology in Intermediate Unit **Completion Date:** • Implementation of EPIC HealthONE electronic health record – 4/28/2018 • Education of practitioners to document the time they actually saw the patient, when there's a change in condition, and when there's a significant time interval between evaluation and documentation – 8/10/2018 • Education of practitioners that they are responsible for the timely document in the medical record of any meaningful change in a patient's condition or therapeutic plan, including any respective assessment – 8/10/2018

Violation	Discussion of Issues	Measures to Prevent Reoccurrence/Date Corrective Action Effected/Responsible party
	did not document the assessment in P#1's medical record. b. Patient #2 was admitted to the hospital on 1/12/18 with diagnoses that included acute decompensated congestive heart failure (CHF) and persistent atrial fibrillation with rapid ventricular response. P#2's cardiac status was monitored via a telemetry monitor. Although P#2 was experiencing a-fib, P#2's monitor did not reflect that the patient was experiencing a-fib because P#1 and P#2's monitors had been switched in error. An assessment of P#2 completed by MD#1 dated 1/14/18 lacked documentation of the time the assessment was completed. A subsequent assessment documented by MD#2 was dated 1/14/18 at 11:00 AM. P#2 did not experience any ill effects due to the delay in receiving treatment for his/her a-fib. Medical Staff bylaws indicated each member of the medical staff would provide patients with continuous high quality care meeting the professional standards of the medical staff of the hospital. In addition the medical staff rules and regulations indicated all written entries in the medical record should include the date and time of the note.	
The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing service (1).	2. Based on review of hospital documentation and interviews for patients on cardiac telemetry monitoring the hospital failed to ensure monitoring documentation was recorded according to hospital practice. The findings include: a. During a review of hospital investigative documentation it was identified on 1/14/18 that a print out of telemetry monitoring strips was not completed at 7:00 AM due to the unavailability of telemetry strip paper. During an interview with Technician #1 on 5/31/18 at 10:20 AM he/she indicated that at the start of the shift on 1/13/18 at 1:00 PM telemetry strip paper was not available therefore Technician #1 printed the strips for all patients on telemetry on alternate paper. During an interview with Technician #2 on 5/31/18 at 11:00 AM he/she indicated that at the start of the shift on 1/14/18 at 7:00 AM telemetry strip paper was not available. He/she did not know how to obtain	2a. **Action:** • Director of Logistics Management has reinforced correct delivery of telemetry paper location. • Director of Logistics has master list of scanned printer paper par stock. • Director of Logistics will adjust printer paper par stock as needed or requested. • If process changes the manager of Central Monitoring Unit will contact the Director of Logistics if printer paper par stock needs adjustment. • Reinforced with logistics staff to check printer paper par stock six days a week. Confirm enough product to

Violation	Discussion of Issues	Measures to Prevent Reoccurrence/Date Corrective Action Effected/Responsible party
	additional paper therefore he/she did not print out telemetry strips for all patients on telemetry monitoring. A hospital procedure for CMU (Cardiac Monitoring Unit) printing of telemetry strips indicated telemetry rhythm strips should be printed for all patients on telemetry at shift start and the strip should be measured and analyzed. Subsequent to 1/14/18 all staff of the CMU was educated on how to obtain telemetry paper when stock is not available.	last weekend, holiday and/or snow day. • Additional boxes of printer paper par stock in University Tower inpatient units. • Nursing supervisors (24/7/365) have access to all units' par stock and will assist in obtaining additional paper if needed. • Educated the Central Monitoring Unit staff on where to find additional paper if needed, who to call, and escalate to nursing supervisor if low on paper product. • Educate Central Monitoring Unit staff on hand off and importance of printing telemetry strip at the start of each shift for every patient. • Educate Central Monitoring Unit staff on alternate process to print telemetry monitoring strips. • Educate Central Monitoring Unit staff on log and task of counting par stock daily. **Compliance Monitor:** Count of par stock to be completed daily and signed off on log in Central Monitoring Unit. **Responsible Person:** Central Monitoring Unit Nurse Manager **Completion Date:** • Director of Logistics Management has reinforced correct delivery of telemetry paper location – 8/13/2018 • Educated the Central Monitoring Unit staff on where to find additional paper if needed, who to call, and escalate to nursing supervisor if low on paper product – 2/13/2018 • Educated Central Monitoring Unit staff on hand off and importance of printing telemetry strip at the start of each shift for every patient – 8/10/2018 • Educated Central Monitoring Unit staff on alternate process to print telemetry monitoring strips – 8/10/2018 • Educated Central Monitoring Unit staff on log and task of counting par stock daily – 8/10/2018

Violation	Discussion of Issues	Measures to Prevent Reoccurrence/Date Corrective Action Effected/Responsible party
The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (i) General (6).	3. *Based on medical record review and interviews for 2 (Patients#1 and 2) of 12 patients reviewed for cardiac monitoring via telemetry monitoring devices, the hospital failed to ensure that staff followed the hospital procedure for wireless telemetry device application and monitoring resulting in Patient #1 receiving treatment for Patient #2's cardiac arrhythmia (atrial fibrillation). The findings include: Patient #1 was admitted to the hospital on 1/10/18 directly from the cardiology clinic for decompensated heart failure. Patient #1's history included congestive heart failure, hypertension, chronic obstructive pulmonary disease and coronary artery disease. Patient #1 was admitted to Room 208 of the Intermediate Unit (IU). A cardiology progress note by Medical Doctor (MD) #1 dated 1/14/18, at an unidentified time, indicated Patient #1's breathing had improved, had a regular cardiac rhythm and no further complaints were offered. The plan of care indicated Patient #1 would continue on a Lasix (diuretic) drip and his/her fluid and electrolytes would be monitored. Patient #2 was admitted to the hospital on 1/12/18 after elective right and left cardiac catheterization for rate control. Patient #2's history included decompensated congestive heart failure and persistent atrial fibrillation (a-fib) with rapid ventricular response. Patient #2 was admitted to Room 215 of the intermediate unit. a. On 1/14/18 at 4:00 AM Registered Nurse (RN) #1 requested a telebox (portable telemetry monitoring device) for Patient #1 from the Cardiac Monitoring Unit (CMU) via phone. RN#1 was instructed by Technician #1 that a telebox was not available from the cardiac monitoring unit at that time and to obtain one from the intermediate unit as is usual procedure. RN #1 obtained telebox #13 and placed it on Patient #1. Review of the hospital's post incident analysis identified that following placement, RN#1 and Technician #1 failed to verify telebox #13's application (placement on the patient) and failed to obtain a patient rhythm, as is usual procedure. The hospital process for telebox assignment included in part, assignment is based on the patient's room number. Interview with RN#1 on 5/31/18 at 9:15 AM identified that on 1/14/18 at 4:00 AM he requested a telebox from	3. **Action:** • Changed process in Intermediate Unit to no longer allow use of wireless telemetry boxes. • Any patient on transport monitor that is not wireless will have a nurse with them. **Compliance Monitor:** Nurse manager or designee will make 50 random observations of a nurse with a patient on transport monitor with goal of 100% compliance rate. Will continue observations until 50 consecutive observations with 100% compliance rate is achieved. The need for additional monitoring will be re-evaluated at that time. **Responsible Person:** Nurse Manager **Completion Date:** • Changed process in Intermediate Unit to no longer allow use of wireless telemetry boxes – 6/28/2018 3a. **Action:** • Changed process in Intermediate Unit to no longer allow use of wireless telemetry boxes. • Staff must provide additional third patient identifier, Case Encounter Number (CSN), for initial placement of patient on monitor. • Educate Intermediate Unit and Central Monitoring Unit staff to use closed loop communication with repeat back technique for any change in cardiac monitoring device **Compliance Monitor:** Nurse manager or designee will verify communication log includes three patient identifiers between Central Monitoring Unit and Intermediate Unit by reviewing 50 random observations with goal of 100%

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	the cardiac monitoring unit via phone and was instructed by Technician #1 that a telebox was not available and to obtain one from the intermediate unit as was usual procedure. RN#1 indicated after obtaining telebox #13 he put it on Patient #1 and notified Technician #1 that Patient #1 was on telebox #13. RN #1 identified that he did verify the rhythm on Patient #1's telebox and it indicated normal sinus rhythm. b. At 5:51 AM RN#1 went to the cardiac monitoring unit, signed out, and removed telebox #15. RN#1 told Technician #1 that he was taking telebox #15 for room 215 (Patient #2). Review of the hospital's post incident analysis identified that following placement, RN#1 and Technician #1 failed to verify telebox #15's application (placement on the patient) and failed to obtain a patient rhythm, as is usual procedure. Hospital process for obtaining a telebox was to call (not go to) the cardiac monitoring unit and request a box. Then transport staff would bring the telebox and appropriate paperwork to the intermediate unit for patient use. At 5:52 AM, according to the Connexall system (the hospital's cardiac monitoring system), Patient#1 was switched from telebox #13 to telebox #15. Interviews with RN #1 and Technician #1 failed to identify how Patient #1's telebox was switched from telebox #13 to telebox #15. At 5:53 AM Technician #1 identified Patient #2's bedside monitor indicated "check leads". Technician #1 attempted to contact RN#1 to verify the telebox and bedside monitor readings however RN#1 was not signed into the Voalte system (staff communication system) and could not be reached via this communication system. At that time, Technician #1 failed to communicate with RN#1 in another manner and/or failed to contact another nurse regarding Patient #2's status. It was later identified that RN #1 was not signed into the staff communication system from 3:00 AM to 8:00 AM and should have been, as was the hospital process. Interview with RN#1 on 5/31/18 at 9:15 AM identified that on 1/14/18 he went to the cardiac monitoring unit,	compliance rate. Will continue observations until 50 consecutive observations with 100% compliance rate is achieved. The need for additional monitoring will be re-evaluated at that time. **Responsible Person:** Nurse Manager of Central Monitoring Unit **Completion Date:** • Changed process in Intermediate Unit to no longer allow use of wireless telemetry boxes – 6/28/2018 • Staff must provide additional third patient identifier, Case Encounter Number (CSN), for initial placement of patient on monitor – 8/10/2018 • Educated Intermediate Unit and Central Monitoring Unit staff to use closed loop communication with repeat back technique for any change in cardiac monitoring device – 8/31/2018 3b & c. **Action:** • Changed process in Intermediate Unit to no longer allow use of wireless telemetry boxes. • Staff must provide additional third patient identifier, Case Encounter Number (CSN), for initial placement of patient on monitor. • Educate Central Monitoring Unit staff to use repeat back when communicating patient is being placed on monitor. • Central Monitoring Unit staff escalation process packet created and all Central Monitoring Unit staff educated and signed off on workflow. • Developed process of verifying nursing staff is signed on to Voalte at beginning of shift and signed off of Voalte at end of shift. • Removal of telemetry monitoring and assessment via one cardiac monitoring system to include a transport monitoring cube will mitigate the risk of treatment error

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	signed out, and removed telebox #15. RN#1 told Technician #1 he/she was taking telebox #15 for room 215 (Patient #2). RN#1 then proceeded to Patient #2's room, applied telebox #15 and checked the rhythm, which showed normal a-fib. RN#1 indicated that he believed that the telebox switch occurred at 5:50 AM when Technician #1 had changed P#1 from telebox #13 to telebox #15. Interview with Technician #1 on 5/31/18 at 10:20 AM identified that on 1/14/18 at approximately 5:00 AM a staff member hurriedly came into the cardiac monitoring unit, took telebox #15, indicated several times that he was taking the telebox for room 215 (Patient #2), and then ran out of the room. Technician #1 indicated the staff member did not identify who he was, but another technician in the room (Technician #3) identified him as RN#1. According to the Voalte system (staff communication system) the nurse assigned to room 215 was not RN#1. Technician #1 indicated that after RN#1 left the room, Technician #1 and Technician #3 together assigned telebox #15 to room 215 (Patient #2). Technician #1 indicated that normal procedure was that when a telebox is removed from the cardiac monitoring unit, a form attached to the telebox is completed with the patient name, room number, date and time and placed in the slot where the specific telebox is stored. Once the telebox is connected to the patient the nurse calls or sends a message to the cardiac monitoring unit verifying that the patient is connected. However in this situation RN#1 did not complete the form and the cardiac monitoring unit did not receive a confirmation message from RN#1. Technician #1 was able to see on the monitoring system that room 215 (Patient #2) had been removed from the bedside monitor. Therefore Technician #1 and Technician #3 connected room 215 (Patient #2) to telebox #15, which completed an 11 step process to register the telebox to that particular patient. Technician #1 indicated that shortly after connecting Patient #2 to telebox #15, room #208 (Patient #1's) telebox was registering a heart rate in the 150's. Technician #1 messaged the nurse assigned to	**Compliance Monitor:** Unit Nurse Manager or designee to verify at start and end of shift all staff are signed in and out of Voalte with 100% compliance of all staff. **Responsible Person:** Unit Nurse Manager **Completion Date:** • Changed process in Intermediate Unit to no longer allow use of wireless telemetry boxes – 6/28/2018 • Educated Central Monitoring Unit staff to use repeat back when communicating patient is being placed on monitor – 8/10/2018 • Central Monitoring Unit staff escalation process packet created and all Central Monitoring Unit staff educated and signed off on workflow – 2/3/2018 • Developed process of verifying nursing staff is signed on to Voalte at beginning of shift and signed off of Voalte at end of shift – 7/27/2018

Violation	Discussion of Issues	Measures to Prevent Reoccurrence/Date Corrective Action Effected/Responsible party
	room #208 (Patient #1) via the Voalte system (staff communication system) but did not receive a response back. Technician #1 then reported off to Technician #2 between 7:00 AM and 7:30 PM. c. At 7:30 AM Technician #1 reported off to Technician #2. Technician #2 noticed telebox #15 (assigned to Patient #2) was alarming high heart rate (203) and was unable to reach RN#1 so she called the intermediate unit and reported the high heart rate. Technician #2 was unable to identify who she reported the high heart rate to. At 8:00 AM Technician #2 notified RN#1, via the Volte system (staff communication system), that telebox #15 continued to sustain a heart rate of 180's-190's. RN#1 responded and indicated he would evaluate the high heart rate. At 8:26 AM Technician #2 notified RN#1 that telebox #15 continued to indicate a high heart rate. RN#1 responded via the Voalte system "OK". At 8:38 AM Technician #2 notified RN#1 that Patient #2 had been on the bedside monitor and was now "off monitor". At 8:39 AM RN#1 indicated Patient #2 was in the bathroom. Technician #2 notified RN#1 that if RN#1 wanted Patient #2 on a telebox, telebox #15 should be located in Patient #2's room (room 215). At 8:44 AM the Connexall log identified that Patient #2 was placed on telebox #13. According to the Voalte (communication) system log, Technician #2 notified RN#1: "Patient #1 (room 208) is on tele box #15 and Patient #2 (room 215) is on telebox #13". There was no response from RN #1. At 9:21 AM MD#1 was notified that telebox #15 indicated Patient #1 was exhibiting atrial fibrillation. MD#1 verified the a-fib on the monitor and instructed RN#1 to obtain an Electrocardiogram (EKG). The EKG showed normal sinus rhythm (NSR). MD#1 consulted with MD#2. At 9:30 AM MD#1 ordered Patient #1 to receive Metoprolol 5 milligrams (mg.) intravenous one time. Interview with RN #1 on 5/31/18 at 9:15 AM identified that at that time, he had to take another patient for an immediate CT-scan and asks RN#2 to cover his	

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	patients. RN#2 noted the order for Metoprolol and messaged RN#1 to verify that it had not yet been given. RN#1 verified the Metoprolol had not been given and RN#2 administers the Metoprolol 5 mg. IV at 10:19 AM. At 10:43 AM MD#1 ordered Patient #1 to receive Heparin 25000 units in 500 milliliters (ml) of 0.45% normal saline intravenous (IV) drip. Between 10:43 AM and 1:16 PM, 2 EKS's were obtained, an additional IV access was obtained as well as ordered laboratory bloodwork according to protocol, followed by initiating the Heparin drip which was started at 1:16 PM. At approximately 2:00 PM RN#1 went to the cardiac monitoring unit to verify Patient #1 and Patient #2's monitor rhythms. At that time, it was identified that Patient #1 and Patient #2's telebox's were on the wrong corresponding patients. Therefore Patient #2 was experiencing a-fib, not Patient #1. MD#1 was notified and Patient #1's Heparin drip was immediately stopped. A physician progress note by MD#2 dated 1/14/18 at 4:00 PM indicated MD#2 had been informed that Patient #1's telemetry monitor had been switched with another patient and that the other patient was experiencing a-fib with rapid ventricular response, not Patient #1. The note indicated before the error was identified, Patient #1 received a rate control agent and heparin drip without bolus for two hours. MD#2 indicated in the progress note the incident and subsequent treatment did not cause Patient #1 any ill effects. Interview with Technician #2 on 5/31/18 at 11:00 AM identified that communication between Technician #2 and RN#1 occurred at several points in the morning on 1/14/18. Communication included verifying the elevated heart rate of Patient #1 and/or Patient #2's telebox's and the patients being on or off bedside monitor. Technician #2 identified that RN#1 would respond to the messages, however there were several times when Technician #2 and RN#1 differed on what they were seeing on the monitors. Example: Technician #2 would identify that the patient was off monitor and RN#1 would indicate he thought the patient was on the	

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	telebox. Interview with MD#1 on 5/31/18 at 8:00 AM MD#1 indicated he/she was notified by RN#1 that Patient #1's telebox was showing a-fib. MD#1 then verified Patient #1's rhythm on the monitor in the charting room as a-fib (room 208). MD #1 indicated he/she then ordered an EKG and went to examine Patient #1. Upon exam and questioning, Patient #1 exhibited no signs or symptoms of a-fib. A review of the EKG showed Patient #1 was in normal sinus rhythm. MD#1 indicated it is not uncommon for a patient to go in and out of a-fib, therefore explaining why the EKG showed a normal sinus rhythm. MD#1 consulted with MD#2, and P#1 was diagnosed with new onset a-fib for which heparin was indicated. MD#1 indicated that at approximately 2:00 PM, he/she was notified that Patient #1 and Patient #2's telebox's were on the wrong corresponding patients and the heparin drip had been turned off. Interview with MD#2 on 5/31/18 at 8:00 AM identified that he/she had been consulted by MD#1 and the course of treatment provided to Patient #1 based on his/her a diagnoses of atrial fibrillation was appropriate. MD#2 indicated there were no complications or ill effects to Patient #1 as a result of receiving Metoprolol and Heparin. In addition, Patient #2 did not experience any ill effects due to the delay in receiving treatment for his/her a-fib. According to the Instructions for application and use of the wireless telemetry monitoring device: 1) call the cardiac monitoring unit with the patients name, bed number, and request a telebox; 2) when transport arrives with the telebox collect the telebox and complete the form and confirm the patient identification; 3) Disconnect the bedside monitor wires and connect to the telebox; 4) Voalte message with patients name, bed number and request for transmission confirmation; 5) wait for confirmation from the cardiac monitoring unit. Interviews and a review of events with Compliance Officers #1 and #2 on 6/4/18 identified that the hospital implemented the following interventions after the	

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	incident occurred: 1) reeducation on nursing communication systems (Voalte), telebox verification and the implementation of a telebox tracking log; 2) implementation of an escalation (notification) process for cardiac monitoring staff when telemetry alarms are sustained, including the addition of rhythm log and communication log; 3) reeducation on monitoring of supplies in the cardiac monitoring unit and how to acquire additional supplies; 4) monitoring and audits of compliance as scheduled. On 6/27/18 at approximately 3:00 PM P#16 (room 226) was switched from bedside wired monitor to a telebox to ambulate with Physical Therapy and Nursing. Upon return of P#16 to room 226 Nursing called the central monitoring unit (CMU) to tell them to place room 226 back on hardwire monitor. CMU immediately called indicating room 225 had been placed on telebox not room 226. Error was corrected within 3-5 minutes and no ill outcome to either patient. The patients in room 225 and 226 continued to be monitored by either hardwired bedside monitor or telebox during this time. During an interview with Senior Nursing Director on 7/12/18 at 10:15 AM he/she indicated telebox's have been removed from the Intermediate Unit (IU) and all patients will be monitored when ambulating via the cube of the hardwired bedside monitor and with an escort of a registered nurse. Senior Nursing Director indicated in September 2018 it is planned that the IU will begin using a program in which the switch over from BSM to portable will be done automatically and will not require manual entry of patient information therefore eliminating possible entry of incorrect information.	